NARRATIVE EXPOSURE IMPROVES PTSD SYMPTOMS

**One study involved 87 former child soldiers who had been abducted into the Lord's Resistance Army, a guerilla army operating in Uganda that is notorious for its cruelty.**

**Depot Nears Approval**

*Olanzapine from page 1*

At the annual psychiatric institute, Dr. Detke and her colleagues presented several major studies of olanzapine LAI, including a large, 24-week, randomized, double-blind efficacy trial; an analysis of treatment-related metabolic changes; and an update on the complication known as postinjection delirium/sedation syndrome.

There were 29 occurrences of postinjection deliri um/sedation syndrome (PDSS) in 28 of the more than 2,000 patients involved in olanzapine LAI clinical trials through May 31, 2008. This works out to an incidence of 0.07% per injection, based upon a total of more than 40,000 injections. The cumulative risk per patient after 1 year of treatment was 0.7%-1.2%, depending upon the injection observation period of at least 3 hours in a health care facility, and a warning to patients not to overzealously inject themselves.

The signs and symptoms of PDSS are those of olanzapine overdose. They include sedation, dizziness, confusion, disorientation, slurred speech, muscle spasms, weakness, altered gait, agitation, and extrapyramidal symptoms. There have been two instances of seizure and several episodes involving loss of consciousness but no arrhythmias or clinically meaningful decreases in vital signs. Most affected patients were hospitalized during their PDSS episode. All recovered completely in 1.5-72.0 hours with routine medical management. Overall, 70% of affected patients continued on olanzapine LAI after stopping because the high value placed on a depot antipsychotic.

Olanzapine LAI is given intramuscularly by deep gluteal injection. It’s thought that PDSS results from accidental intravascular injection, a potential risk with any intramuscularly administered drug. For example, the incidence of PDSS with olanzapine LAI is quite similar to the 0.08% rate of systemic toxic reactions per injection reported for intramuscular procaine penicillin G (Sex. Transm. Dis. 1978;5:4-9), Dr. Detke noted.

She and her coinvestigators proposed several precautions in giving olanzapine LAI, including a postinjection observation period of at least 3 hours in a health care facility, and a warning to patients not to operate a car or other machinery for the rest of the day. Proper injection technique includes aspiration of the syringe for about 5 seconds prior to injection while making sure no blood is visible.

The metabolic parameters study involved 921 adults with schizophrenia who were first stabilized on 10-20 mg/day of oral olanzapine for 4 weeks, then randomized to 24 weeks of continued oral olanzapine or to olanzapine LAI at 150 mg every 2 weeks, 300 mg every 2 weeks, 45 mg every 4 weeks, or 405 mg every 4 weeks.

In general, metabolic changes over the 24-week study period were similar in the groups receiving oral and LAI olanzapine. Roughly 20% of patients in either group gained 7% or greater gain in body weight. Interestingly, patients who were obese at baseline experienced significant increases in body weight and body mass index only on oral olanzapine. With LAI therapy, obese patients showed a modest weight loss.

Mean fasting blood glucose rose by 3.1 mg/dL in the olanzapine LAI–treated patients overall, although the increase from baseline was significant only for the subtype of atypical antipsychotic group on 405 mg every 4 weeks. Blood glucose levels rose to a similar degree in patients who received the oral formulation.

Mean LDL cholesterol levels dropped by an average of 6.4 mg/dL in the group on oral olanzapine, by 11.6 mg/dL in those on olanzapine LAI at 45 mg every 4 weeks, by 1.6 mg/dL for those on 150 mg every 2 weeks, and by 2.7 mg/dL for those on 405 mg every 4 weeks. LDL cholesterol levels were available on 57 patients who had finished treatment.

At 3 months post therapy, Clinician-Administered PTSD Scale (CAPS) sum scores decreased in all three groups, likely because the study was started during a brief period of peace in which child abductions were halted, reported Verena Ertl, a Ph.D., candidate also at the University of Konstanz.

At 12 months after therapy, however, there was a significant reduction from baseline in CAPS sum scores with net (mean 66.16 to 34.11), compared with active control (60.84 to 46.68), and control (64.0 to 48.42).

NET also proved superior to active control in reducing reports of spirit possession and discrimination against forcibly abducted children, but had no impact on self-reported aggression. Taken together, the findings show that NET can be an effective treatment, even in highly affected groups like child soldiers, and when carried out as a community intervention, Ms. Ertl concluded at the meeting, which was sponsored by Boston University. “It’s also quite cost-effective,” she said.

Similar results were reported by Dr. Neuner on the use of NET administered in a refugee camp by nine refugees with a secondary school level education and 6 weeks of training, including direct observation.

At 9 months follow-up, adult Rwandan refugees randomized to strictly manualized NET (n = 111) or more flexible trauma counseling (n = 111) were statistically and clinically superior in terms of PTSD symptoms and physical health, compared with 55 refugees randomized to a no-treatment monitoring group. CAPS sum scores improved from baseline with both NET (25.9 to 6.1) and trauma counseling (26.7 to 5.0). However, 20% of the trauma counseling group dropped out of treatment, whereas only 4% of the NET group did, said Dr. Neuner, who is now with the University of Bielefeld, Germany.

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